Area Agencies on Aging (AAA) Directors' Response to MH Transformation Questions

Each AAA Director received a copy of questions and a request for input earlier in the information gathering process; Comments below were provided through group discussion at the AAA Directors meeting March 9, 2006; subsequent information may arrive from individual directors and will be incorporated into the report provided to the next stage of the transformation effort. In addition, some AAA Directors and staff have testified during the public forums related to Older Adult Consumers and Families.

QUESTION 1

Within Washington State, and for all mental health services, public or private, what is working well when addressing needs of Older Adults?

- Services are available for individuals who can afford them.
- Area Agencies on Aging (AAA) are using other funding sources to fill in many gaps caused by the lack of mental health services that are adequate to serving AAA clients.
- Where systems are integrated, mental health and behavioral health supports for older adults can work well. However this is contingent upon funding from sources that are not related directly to Medicaid for mental health purposes. These integrated services only exist in small pockets around the state and do not represent a picture of adequate mental health services for older adults in Washington State.

QUESTION 2

Within Washington State, and for all mental health services, public or private, what is not what is NOT working, creates barriers or fails to provide quality services and support when addressing the needs of Older Adults?

- Crisis services for Older Adults do not meet the needs of older adults—they are unresponsive
- Older Adults under-use MH services due to MH services not being geared to the different needs of older adults who are have mental health challenges, e.g.: grief and depression can express themselves differently in older adults
- Older Adult men have the highest suicide rate, but there are not MH intervention efforts to address this reality
- Many issues that older adults experience as mental health needs are not funded through mental health dollars. For example: Grief, Dementia, or personality disorders are not adequately addressed by MH services
- MN Services are geared toward and funded to address major psychiatric

disorders and crises and the treatment models focus on in-patient or serving clients only in MH settings. But older adults require a different approach and have different MH needs. Evidence supports the use of in-home outreach efforts to address older adult behavioral health issues; yet the MH system does not fund these approaches.

- Primary Care Doctors medicate behaviors and have an inadequate understanding of mental health issues for older adults.

- There is a lack of geriatric psychiatrists, and therefore primary care physicians are over prescribing psychiatric meds, causing a huge problem for older adults who are receiving large amounts of psycho-active medications without the necessary support. This can be extremely harmful to older adults who are vulnerable to falls, medication reactions, delirium, etc. AAA staff see this often with in-home clients who are struggling to remain in their own homes. Clients are on medications without proper understanding and support and are therefore vulnerable to moving into institutions as a direct result of medication mismanagement.
- The framework that says Older Adult mental health issues should be funded by Aging Services puts a strain on AAA resources. Almost all AAA are spending money on mental health that the mental health services/RSNs are not spending or are substantially supplementing mental health dollars in order to help people receive necessary services that mental health dollars do not support. Area Agencies on Aging spend anywhere from $200-600,000 per year providing mental health support services in an effort to help their clients remain in the least restrictive setting available.

- There is a misunderstanding of aging issues by psychiatrists and a lack of geriatric psychiatrists and ARNPs.

- Dementia is a Mental Health Issue and an Aging Issue. However, the MH system is inadequate to address chronic and organic brain disorders that cause behavioral and neurological symptoms, such as Alzheimer's Disease, Korsokoff's Syndrome, Huntington's Disease, Pick's Disease, Parkinson's related psychiatric symptoms.

- MH only funds treatment modalities, but Aging funds function—yet older adults will more likely go to older adult programs for MH-type services. These programs are not funded by MH

- Older Adult Mental Health problems don't look the same to the community and are not necessarily funded by MH—therefore older adults may quietly de-compensate in the community until they've reached a crisis point—when the MH system does act

- Older Adults experience the stigma of mental illness because of prior generations' mental health systems—have a memory of a time that having a MH problem meant a character flaw and also meant one was automatically and irrevocably locked away

- There are not enough beds or specific enough treatment modalities for older adults who require in-patient treatment for MH or Substance Abuse.

- Many ways that older adults manifest mental health problems do not meet the MHD's Access to Care standards, and therefore Aging money often funds the gaps by providing services that actually prevent crises before they reach that standard that would allow MH to serve them. Examples include: Depression Screening, PEARLS program for Depression support by case managers, Stabilized housing in partnership with Section 8 housing and HUD.

- Older Adults are not receiving in-takes or access in a timely manner. (At least one AAA decided to fund a position within the local MH agency in order to improve access for its older clients)

- HIPPA and other privacy laws can sometimes interfere with providing older adults adequate care

QUESTIONS 3 and 4
Related to Older Adults, what would a "transformed" mental health system look like?
What outcomes would indicate the changes in the mental health services are creating results for Older Adults?

- We need a wholistic approach that would serve and fund treatment for body, mind, and soul together.
- Older Adults would receive mental health services in appropriate settings (that is settings that serve the older adults where they live or can very easily reach)
- There would be more providers with mental health and geriatric expertise
- There would be more cross training between mental health workers and aging experts

EXAMPLES OF PROGRAMS THAT WORK OR HAVE WORKED IN THE PAST THAT ARE FUNDED SUBSTANTIALLY BY AAA-CHANNELLED FUNDS

- Elder Services in Spokane—when a crisis call regarding an older adult comes into the MH Crisis Line, it is automatically transferred to Elder Services for 24/7 response

- GateKeeper Model—for case findings for Older Adults in need of MH or Other intervention services. Now are underfunded and closing programs throughout the state
- PEARLS—case management support for older adults with Depression, provided where the client needs to be served

The Snohomish County Human Services Department, Division of Long Term Care & Aging (DLTCA), is the Area Agency on Aging (AAA) for Snohomish County. As part of its planning process, DLTCA identified a lack of mental health services for older adults in Snohomish County. Over a period of several years as modest amounts of additional funding became available, the DLTCA developed a couple of new services and enhanced existing mental health programs. Currently, the AAA funds the following mental health programs:

HOPE Options/Stabilized Housing for Vulnerable Seniors
2006 Discretionary Allocation - $127,470

Contractor: **Everett Housing Authority**
Contact – David Tieszen
(425) 303-1106
davidt@evha.org

The goal of the program is to prevent premature or inappropriate institutionalization of frail older adults by providing housing assistance and supportive services that enhance and prolong an independent life style. The program works to stabilize housing for vulnerable seniors while optimizing their behavioral well-being. This is accomplished through: collaboration with the mental health service network, adding mental health professionals to staff, increasing housing opportunities through the provision of twenty new Section 8 vouchers, and strengthening partnerships with other agencies providing housing related services.

Day Service for Mentally Ill
2006 Discretionary Allocation - $45,973

Contractor: **Elderhealth Northwest**
Contact: Nora Gibson
(206) 467-7033

This is a special program connected to the Adult Day Health Program in Snohomish County. This program provides day care, including individual and group treatments, to chronically mentally ill seniors. Services are targeted to

persons who: are under the care of a psychiatrist; need supervision or assistance with activities of daily living due to cognitive or behavioral impairments; are sufficiently stable to be safely managed in a structured group environment; are at- risk of institutionalization; and would benefit from a structured program of therapeutic activities.

Geriatric Depression Screening
2006 Discretionary Allocation - $25,734 + Older Americans Act Title IIID Funds

Contractors: **Senior Services of Snohomish County**
Contact: Bob Quirk
(425) 290-1263
rquirk@sssc.org

This program provides: outreach and early intervention for isolated individuals who may be suffering from depression; education relating to the identification and prevention of depression; health screening for depression and advocacy to assist depressed individuals to communicate effectively with physicians; education about medication management; and referral to community resources as indicated. Additionally, the program provides the following services to older persons whose score on the Geriatric Depression Screen indicates moderate to severe depression: short-term individual mental health counseling; grief counseling; family mediation to improve support available to client; advocacy with health care providers regarding medication treatment and management issues; an assessment for potential medication management problems and training to prevent incorrect medication use and adverse reactions; and communications skill training for family caregivers to reduce stress and improve service delivery. Approximately 20 percent of the depression screenings are conducted during home visits to homebound/isolated seniors.

Peer Support
2006 Discretionary Allocation - $61,956 + $15,000 County Funds

Contractors: **Senior Services of Snohomish County**
Contact: Bob Quirk
(425) 290-1263
rquirk@sssc.org

The Peer Support Program utilizes well-trained volunteers over the age of 55 to provide individual support to residents of Snohomish County age 60 and over who reside in the community, congregate care facilities or adult family homes. Persons served suffer from situational depressions due to transitions, changes, personal losses or other emotional problems that are deemed serious enough to jeopardize the older person's ability to live independently.

The program provides ongoing follow-up through small support groups and workshops around mental health issues for older persons in Snohomish County. Core activities of the program include establishing a supportive relationship; assisting in clarification of issues and problem-solving; reaffirming dignity and self- esteem; decreasing social isolation; establishing new networks of supportive friendships; coordinating other services as needed; and assisting in seeking help from a geriatric mental health specialist when issues become too complex for the skill level of the paraprofessional volunteer.

With these four programs, the DLTCA invests approximately $276,000 of its $1.5 million allocation in mental health services for older adults.

The Snohomish County Council on Aging (COA) is a thirty member advisory board that advises the County Executive, the Human Services Department, and the Long Term Care & Aging Unit on the concerns of the county's 75,000 seniors. The COA includes a Mental Wellness Committee that has served as a focal point in advocating for the mental health needs of older adults. The Mental Wellness Committee has produced a booklet on *Mental Health & Aging* and promotes awareness of mental health issues and services for older adults.

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Home and Community Services Response to MH Transformation Questions
QUESTION 1 Within Washington State, and for all mental health services, public or private, what is working well when addressing needs of Older Adults?
• The mental health agencies that participate in an Expanded Community Services program provide responsive behavioral support to HCS clients on a 24/7 basis. These agencies have contributed to an increased ability for HCS to serve a limited number of clients who experience extensive behavioral challenges. • The RSNS have participated in local efforts to provide cross-system support for the most difficult clients that DSHS serves. These efforts have assisted local communities in helping clients with numerous challenges remain in the community.
QUESTION 2 Within Washington State, and for all mental health services, public or private, what is not what is NOT working, creates barriers or fails to provide quality services and support when addressing the needs of Older Adults?
• There is a lack of consistency across Regional Support Networks in the kinds of services older adults can expect from local mental health agencies. For example, an older adult living in a nursing home or an adult family home in King or Pierce Counties might receive mental health services in their residence, but in another county of the state, a person with the same diagnosis and same need for behavioral health support will not receive such services because not all RSNs fund mental health agencies to provide outreach services. • The state lacks community-based programs for individuals who require both mental health/behavioral support and personal care. There is a lack of beds for both short-term crisis treatment centers (i.e. geriatric E&Ts) and for longer term supportive residential programs that can serve clients with behavioral and personal care needs.. • This lack of community-based beds, contributes to an ongoing tension between long-term care providers and mental health crisis responders when individuals who live in long-term care settings experience behavioral crises. • There is a lack of consistency across RSNs in applying the Mental Health Division's ACCESS TO CARE standards regarding the treatment of individuals who require behavioral support as a result of Dementia or other cognitive-deficit diagnoses that are found in the DSM-IV.
QUESTION 3 Related to Older Adults, what would a "transformed" mental health system look like?

- RSNs would provide responsive and consistent crisis and outreach services to all individuals who require behavioral support.

- There would be enough community-based crisis beds to serve clients with personal/medical care needs who require out-of-setting intensive mental health evaluation and treatment.

- All RSNs would recognize Dementia as a mental health diagnosis and would provide treatment for individuals who have need for behavioral health support as a result of Dementia.

QUESTION 4
What outcomes would indicate that the changes in the mental health service systems are creating results for Older Adults?

- The percentage of community-dwelling older adults that each RSN serves would be proportional to the population of older adults in that RSN

Responses from Outreach Effort
Subcommittee members sent emails to numerous stakeholders or received direct feedback in meetings with stakeholders, including residential provider advocacy agencies, the state Long-Term Care Ombuds office, the State Senior Lobby, Area Agencies on Aging, and Mental Health agencies that offer older adult programming. The following responses represent the feedback received in response to this outreach effort.

The responses below are compiled here for easier reading but should be read as separate reactions to the questions.

QUESTION 1
Within Washington State, and for all mental health services, public or private, what is working well when addressing needs of Older Adults?

- I have limited positive to report. I commend Eva Robinett of APS and Juanita Daniels of DSHS for their help, although even they don't even seem to know what happens outside their direct authority. I guess no one can know everything about "the system".
- Home Health Services are very necessary and most seem effective. Evergreen In-Home Mental Health and GRAT (Geriatric Regional Assessment Team) are models in King County that should be evaluated across the state

- Here in the SE we see the dedication of the staff to assist clients as best they can given the case. They try to look at all the needs of the individual and provide a thorough plan.

- I have seen some good case management support in the public area.
- The existence of a MH Ombuds.

- *The ECSOA program in Snohomish County (Compass Health) has been very successful. This program has had a total of 23 Older Adult Mentally ill participants in Snohomish County. These clients were provided intensive supports in placements approved by Home & Community Services and the Mental Health treatment team. Currently 14 clients participate and live in 6 different AFH or SNIF's and get intensive mental health case management and prescribing services provided by Compass Health. We have had 2 clients graduate to lesser services and there are 2 more that are expected to graduate soon. There have been 7 clients that have died from natural causes in the program, which I consider a success because they would have otherwise spent the last years in their life most likely in Western State. There is a similar program in Whatcom County (Whatcom Counseling) which is part of our team that meets with Home and Community Services monthly.*

- There seems to be private insurance available for some older adults and with mental health parity in effect, necessary services can be expected to be available for those who are insured with large companies.

- I've observed a number of different agencies engaged in different activities for seniors. What works well is when the mental health providers go to the Older Adults rather than have the Older Adults go to the providers. In my experience, Older Adults who may have significant mental health issues tend to not seek help on their own. Harborview's outreach program is effective as a facility based program. Evergreen Healthcare's In Home Mental Health is a very effective outreach to those that are homebound.

- The ECS program, although that is limited in slots.
- Growing concern about the mental health status of older adults.
- Some Nursing Homes being willing to try new approaches to working with olde adults, especially with dementia and some mental health issues.
- Changes in regulations to look at the psychosocial effects of non-compliance v regulations (e.g. the psychosocial effect on the resident of the facilities failure t deal with that resident's urinary tract infection).
- *Adult day centers; these individuals have the training necessary to work with th population.*

- That Medicaid pays for the services without any cost to the patient/person

- I will speak about services in Kitsap County, provided by Kitsap Mental Health, and private providers. KM H has a good older adults unit, but is always low on funding. They have a team that goes to nursing homes and assisted living facilities, but mostly doing consultations on a short term basis. They also coordinate with the CDMHP's, so if a facility calls for assistance after hours, they can see the interventions that have been tried, as well as recent med changes. They do not have the staff to spend much time with the residents, or do group therapy over loss, grief, and transition issues.

- What we need is an "immediate response team", who are skilled in interventions with older folks, especially with dementia, who could assess the situation at the residents home, and offer learned suggestions, and take the person to a small local geropsych unit if they were a danger to themselves or others, for a short term stay.

- Networking, brainstorming w/ common clients.
- In some areas of the region, the CD MHP(s) are very responsive and will go out to evaluate on short notice. In some areas, when the Mental Health

Provider attends an A Team networking meeting, it has been helpful. There have been individuals within mental health organizations that have worked cooperatively together to assist mutual clients, with positive outcomes.

- PASSAR consultations done in skilled nursing facilities are used by the care giver and facility to promote quality care. Coordination is also done with the contract psychiatrist. Home Mental Health programs affiliated with home heath agencies work to provide mental health care to the homebound Medicare patient and/or RSN/private patient. These patents are in skilled nursing facilities, assisted living, Adult Family Homes, or their own private homes. Clinical supervision is provided to the RN's by a psychiatrist who sees the pt and writes orders.
- Stars Program works well and provides specialized programs to the mentally ill elderly. Valley Medical Center in Monroe provides specialized inpatient dementia care and evaluation.
- 29 elders were hospitalized in 2005 in Mason/Thurston Counties, Diagnosis: Major Depression or Dementia.
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QUESTION 2
Within Washington State, and for all mental health services, public or private, what is not what is NOT working, creates barriers or fails to provide quality services and support when addressing the needs of Older Adults?

- I am personally dealing with *Older Adult Consumers & Families* and *Homelessness and Mental Illness*. (My 77 year old father-in-law likely has vascular dementia but refuses any help and he and his 84 year old wife are being evicted from their apartment.) There are guardian ad litems, defense attorneys, and Adult Protective Services (with their AAG) involved and my husband and family are still having to deal with my mother-in-law-and father-in-law with very limited support or guidance. We don't know what anyone's' role is or how to get real help.
- Restrictions/limits to Medicare coverage for mental health. Medicre provides no long-term mental health coverage. Only short term, crisis services and only by RN.
- Shortage of gero-psychiatric units and beds is ALWAYS a problem.
- Overbooked county crisis mental health professionals (CDMHPs) lead to slow detainment of dangerous mentally ill elders.
- Shortage of adequate COPES and other home care providers and poor training and pay of these providers leave many elderly with inadequate or even unsafe care in their homes.
- Rising case loads for mental health providers means decreased care

- Lack of staff or doctors to assist clients. In Walla Walla county there is only one Psychologist that takes Medicaid, this means that people may have to wait 6 months to be seen by him. Local caseworkers are spread to thin to meet the needs of this rural area.
- *Medicaid eligibility too stringent to take in our clients, esp. for depression; inadequate resources; no ability to make home visits; lack of focus on elders (kids are always the priority); difficult to get anyone to think creatively about solutions.*

- Many of our clients that need Mental Health services can't obtain them as they do not have a reimbursable mental health issue such as "Major Depression" but they have a depression secondary to medical problems. There is sufficient research to indicate that untreated depression and other mood issues exacerbate other health issues, so it is very short sighted to not treat these individuals. Reimbursement for mental health services should be expanded.

- Also, most of our mental health providers DO NOT provide in-home services, which is a major barrier for our home bound disabled and elderly clientele whom have difficulty getting to and from services. This is further complicated by the older generation having difficulty accepting mental health services, even if they have a form of medical transportation that takes them

to a facility if is known to provide mental health services.

- Many of our mental health providers have difficulty with DSHS release of information forms. This is sometimes used as a reason to not return calls, for example.

- In several areas in our region, several of our mental health providers have implemented waiting lists intermittently.

- Mental health providers seemingly operate in an insular fashion, and often do not operate collaboratively with other entities, even when there are shared clients. The barriers are so significant that outside agencies, such as our T XIX Case Management Programs, have had to circumvent these barriers and find alternative methods outside the system to get our clientele's mental health issues treated, such as contracting with a Private Psychiatric ARNP using our own agency funds. Primary physicians are the primary prescribers of psychiatric medications, and admittedly are not experts in this field.
- Only one MH public provider in a county sometimes limits services or options f clients. More support for and from MH Ombuds.; can't take every case receive
- Receive complaints regarding private hospital gero psych wards. RE: Concern about extreme weight loss, over medication and staff not working with or again family members.
- More available affordable housing, currently year long waiting lists.
- More accessible and reliable transportation, currently there are large Nursing Homes, Assisted Livings and Adult Family Homes who are outside the service for Medicaid transportation services. Have received complaints that transporta is not reliable leading to missed appointments.
- *Often times the Hospitals are too quick to release older adults from their facilities before medications and delirium due to medical problems back to their adult family Homes or SNIF. Also, many times behavioral problems are minimized by discharge planners so that these people are returned back to the hospital from their residence because problem behaviors still persist so that a culture of a "revolving door" history becomes attached to a clients and then no facility will take them later on. This could have been prevented by*
- *better behavioral assessments before discharge, intensive mental health supports in place (such as ecsoa), Also many hospitals rush to discharge clients and place them outside of their familiar community, away from friends and family because of the rush to place and no one willing to take them because of the revolving door syndrome.*
- *I would like to see an extension of the number of geriatric beds in hospitals and/or crisis transitional facilities that can deal with geriatric issues such as assisting with eating, toileting, hygiene (mental health crisis beds do not do these things).*
- *Increased number of allocated ECSOA beds to deal with mentally ill persons also needing Home and Community Services supports.*

- *Older Adults living in long-term care settings are not receiving the services the need; their symptoms must escalate to the point that they are in crisis, before t receive the help that they need-----and by that time, they have caused other individuals in the facilities to have functional difficulties. Boarding homes have least amount of training and the least amount of staff and yet some have the la population of individuals with the most challenging needs!*

- Inadequate funding, access barriers, and limited treatment options are among the many issues preventing the mental health system from meeting the needs of older adults. Because other respondents are better positioned than DLTCA to describe those obstacles, our response will highlight only a few key problems that the AAA has repeatedly encountered:

- Myths held by older adults, the general population, and service providers that being depressed is a normal part of aging. Many seniors resign themselves to feeling miserable without realizing that help is available. Family members and others that interact with seniors may believe that being old is depressing. Service providers in both mental health and aging may also hold some of these beliefs to varying degrees.

- Too few mental health services are designed to be brought into the homes of older adults. The stigma surrounding mental health problems can prevent seniors from visiting community mental health centers. Health problems, mobility limitations, and lack of transportation can make it extremely difficult for some seniors to leave their homes. In survey after survey, seniors have expressed a strong preference for remaining in their homes and aging in place. The mental health system needs to respond to this consumer preference as well as its obligation to provide services to homebound seniors.

- The mental health system is so overwhelmed that it does not appear concerned that older adults receive mental health services at a much lower percentage than their percentage in the overall population.

- Reluctance exists to use limited community mental health funds to serve older individuals with dementia who are experiencing depression and anxiety. Nearly 50 percent of individuals with Alzheimer's disease will suffer from depression, anxiety, delusions, or hallucinations. Mental health treatment of these behavioral symptoms can make a meaningful difference in the lives of individuals with Alzheimer's disease and, in particular, for their family caregivers

- Those with only limited private insurance may not have adequate coverage for mental health services and medicines which are normally expensive. Those without any insurance may not be able to obtain medication and

services unless their income falls below a low threshold.

- Social Security spend down for Seniors is not working. It limits access to the mental health services for the elderly, until they reach the $603 platform. Providing care before patients need involuntary treatment is important for quality care. For example, if they get $903, then they are required to spend down $300 to reach the $603 platform before they are eligible for Medicaid.

- The response when calling the CDMHPs—lack of support
- They "pass the buck" no support

- There are still issues about who is going to pay for mental health services; especially on going talk therapy, medication management, etc. in nursing hom
- There is a question about referring folks for help in the community settings of a family homes and boarding homes/assisted living facilities.
- There is no consistent approach to folks with dementia and acting out behavio These folks do not belong in "hospitals", and families and facility staff need help/training (time paid for by rates?) in working with the transient behaviors th are often seen in people with dementia.
- Mental health is the only system with crisis response in terms of behavioral iss (other than fire and police). Geriatric counselors are needed as consultants in system.
- Many of the community residential placements such as adult family homes and boarding homes do not have support from the mental health system for mainta folks in these placements. Often, behaviors that the residents have cause the be discharged back into the community with little or no follow up or treatment. There needs to be a system that allows mental health providers to give more services to the residents in their "home" or a respite system for stabilization an return or some other form of help to maintain folks in the community. This is, i part, a payment source issue.
- Crisis units are not able to deal with older folks with medical or activities of dai living issues.

- Federal, state, and local regulations provide the most consistent barrier to efficient provision of mental health services. Regulations to assure that the precious financial resources available are used properly are necessary. The micromanaging that is such a part of the current regulatory process compromises efficient care. Try being "admitted" to a mental health system some time. It would be sobering.

- Lack of geriatric physicians to recognize MH issues of the elderly or physicians who see a need for meds, but are not qualified to prescribe psychotropic meds appropriate to the elderly having multiple health issues.

- Lack of services for homebound geriatric individuals, related to acquiring meds., ongoing management of meds., treatment.
- Lack of education of older adults/family members/medical providers to distinguish MH issues; older adults are often assumed to have dementia or choosing to be difficult.
- Lack of outreach for the geriatric homeless population that is often mentally ill.
- Difficulty of accessing mental health services due to often cumbersome intake process of local MH.
- Short term therapy does not always work for elderly.
- Lack of support groups for elderly; AAA, drug support groups, MH support groups.
- Lack of MH treatment for older dementia clients.
- Long waiting periods for treatment.
- Mental health systems often "close" clients as being unwilling/non-responsive to treatment, instead of doing appropriate outreach and building rapport to encourage active treatment.
- Physicians who over prescribe addictive medications to patients.
- Mental health providers do not always work with the "family unit"; often work only with the elder individual.
- Lack of MH services in non-ECS facilities; MH often responds only when the need for an institutional placement occurs.
- Facilities that are trained and willing to take sexual predators and individuals with behavioral issues.

- We also have one practitioner from KMH who visits folks at home, and he is wonderful, but cannot provide any long term therapy. Folks have to go to KMH to have any kind of long term therapy, and many folks find it difficult to get there. We also do not have enough private practitioners that work with older adults with depression and life transition issues, who will bill Medicare, and not require additional payment, so for folks on limited incomes who are not eligible for Medicaid, the choices are very limited. Also, the difficulty many folks have getting to an office. We have two new counselors who are willing to do home visits and bill Medicare, but they report great difficulty getting into the Medicare system and getting reimbursed, but we are happy for these additional resources in our community.

- We also do not have a geropsych unit in our hospital, so folks from Kitsap go out of county...even a small unit would allow our residents to stay here.

- *I've not been impressed with the system that provides mental health services t older adults in our state and am most familiar with the needs of residents in lor term care facilities. Because the stigma of mental illness is more prevalent in elders, I believe a system which provides treatment by way of group therapy is poor way to deliver services…it may in fact dissuade older adults from getting*

treatment because of the loss of anonymity…especially if the therapy is with o who live in your facility. I am also extremely disappointed in the lack of training staff in facilities in dealing with the many issues that arise which are classified behavioral problems which, when analyzed, are dementia related. I also belie the RSN system of delivering services is cumbersome and bureaucratic.

- Quality mental health services are not provided to older adults in Yakima County. Because of the generation of the population we are serving, there is still stigma attached to receiving these services, As the baby boomer begin to reach this age, I feel there will be less stigma and resistance, because we accept this as a need. Even if an elder is open to obtaining services, the current system is not "user friendly". Most elders we see are ill and frail, and have limited resources. Combine this with mental health issues, and you have an individual that is too overwhelmed to navigate their way through the system; for example, if transportation is needed, they will have to use public transit to get to the appointments. This means they could be late for an appointment, or have to sit for hours before and after their appointment waiting for their ride. For an ill, depressed elder, this is too overwhelming, and this is probably the biggest barrier.

- Coordination of services is also a barrier. As a social worker making a referral, I will speak to an intake worker, but I am not given any information to prepare my client, nor am I provided any follow up information from mental health. An example of this barrier is, that a referral is made for an elder to receive mental health counseling, and a psychiatric eval for medications. This means that the client will have to come in for at least 3 appointments before they actually are 'served'; they will be asked to come in for an initial intake appointment, an appointment with a mental health counselor for another intake, and then they have to wait until the case is staffed to see if it is appropriate for a psychiatrist. Only then will they get an appointment with a psychiatrist, which could take a total of 3-4 months. By this time, most elders have given up.

- There is fragmentation of care, and lack of a primary worker with mental health services.
- Elders have special needs because of medical/health issues. There could be several physicians, home health nurses, HCS caregivers and case managers involved in the client's care. Mental health services need to be integrated into this milieu, and it is very frustrating not to have a primary case manager in mental health who will take responsibility for being the spokesperson for all mental health services received. Calls are not returned, information is slow to be shared. Elders become very frustrated and confused when services are not coordinated-it is another loss of control that they suffer.

- Inadequate psychiatric staff is another barrier. There are not enough gero-

psychiatrists or adult psychiatrists' to provide care in the mental health system in Yakima county. An elder could wait as long as 3 months to be seen for an initial psych eval, and to be prescribed medication. Then, they will not have access to the physician for another 2-3 months for a med adjustment appointment. The client's medication regime moves very slowly because of the length of time between appointments. If there are med issues in between visits, there is a nurse available by phone, but responses can take a week or more, and she may say that the issue needs to wait until the next doctor visit. By this time, the elder is so frustrated either because of side effects or lack of therapeutic response, that they will quit taking the meds. THEN, mental health labels them as non compliant with their treatment!

QUESTION 3
Related to Older Adults, what would a "transformed" mental health system look like?

- Decrease homeless people. Decreased drug abuse. Increased support/opportunities for homeless or criminals.

- More than one public service provider.
- Increase MH Ombuds. numbers
- Affordable and available housing
- Accessible and reliable transportation
- More vocational rehab. programs leading to employment and successful living less restrictive settings.

- Here it would look like a place that professionals could call and get a consultation, a client could see a doctor with in a month. It would be local to each county.

- Recognition by the powers that be that employment and education goals don't apply to the elderly (huge focus on this)

- "Transformed" mental health system would have more gero-psych hospital programs for clients to get services when acutely mentally ill.

- More in-home mental health and medical providers are needed for homebound elderly and homebound young adults.

- *Individuals would be assessed in their environment; staff would be given traini how to best meet the person's needs within this environment; residents would involved also, obviously with the permission of the resident---they could learn a "cue", maybe a word to say to the resident when they are starting to demonstra behavior that might not be appropriate in a communal setting. The majority of problems, that I have seen have arisen from a facility that has a population tha younger, mixed with individuals with mental health problems and persons with developmental disabilities. Case management is minimal due to heavy caselo*

- With the increasing number of babyboomers and people suffering from mental health disorders including dementias with severe behavioral disorders, I would to see:

- A series of surveys done with Adult Family Home providers and SNIFs indicating how many older adults have been refused services or transferred out because of history of behavioral problems.
- More Ecsoa teams that work in conjunction with Home and Community Services and Medicaid Mental Health Providers.

- Review Boarding Home and AFH WAC's to reflect special needs of Older adults and the mentally ill.
- Funding to allow Geriatric Units in hospitals to hold on to these clients longs until a placement can be made in their community, as opposed to sending them to another part of the state. This would reduce the likelihood of a client developing the "revolving door" syndrome.

- For older adults, a transformed mental health system would include a comprehensive range of services tailored to their needs and available in appropriate settings (individual homes, adult family homes, assisted living facilities, and nursing homes). The mental health system would have much closer coordination and collaboration with the Aging Network. More programs would operate that combine the strengths of the Aging Network in conducting outreach and providing support services with the clinical expertise of the mental health system.

- There would be state-provided long term care for the most extremely serious cases (those where a person's illness prevents them from living in a state-funded group home or independently). There would be state-funded support for those who need assisted care for day to day living. There would be state-funded mentors for those who need assistance on the job. The state ought to be expected to tax the community to help those weaker members of the community.

- Early intervention, funded individual therapy, and ongoing group therapy for the elderly would contribute to a "transformed" mental health system. Another service should be coordination/review of all medications being taken by the elderly with a community pharmacist.

- Adequate studies on the effects of the psychotropic drugs used with older adu most effective doses, how often, etc. When is the dose too much so that the patient/client/resident appears to be doped? A related issue is to have pharma consultants available (paid for) and accessible by community facility staff and f living at home to evaluate actual and potential drug/drug and drug/food interac
- Trained consultants available (paid for) to community settings including reside adult day health and doctors to assist in designing care/treatment plans with th focus of maintaining the resident in the least restrictive setting.
- Training available (paid for) concerning new discoveries, treatment modalities, working with folks in ways that don't trigger aggressive/acting out responses, medications, etc. for residential, community and family members. Could be sir to Pebbles in the Pond in Pierce County.
- Part of a service system that focuses on the need of the person and not the payment source. There must be a way to do away with the "silos" and provide seamless services.

- *A package of mental health trainings, social workers/case managers and ARNP's with mental health specialties would be available to adults with mental health issues regardless of the acuity of the problem. Home visits would be a big part of the package. Adult Day care centers for dementia would be incentivized. Integrated service packages similar to what is done in Spokane would be encouraged.*

- In an ideal world we would not separate out mental health from other health care issues. However, given current structures and a well established history of how mental health systems function a very first step would be to go back to the fee for service reimbursement that would include something for home visits. This would be a sure fire incentive to provide service. If there was concern about the misuse of this reimbursement system, the State could have a 3rd party such as a T XIX COPES or MPC Case Manager be the authorizer of # of visits and hours after a joint staffing on a joint client, for example.

- A brochure outlining what everyone roles and responsibilities are, what our rights are as family, and what my in-laws rights are would be nice.

- Also maybe a law that states the family has to be included in whatever is going on when decisions are made, papers are filed, contacts are made (if the family so desires). We feel we are given the responsibility of caring for my in-laws (trying to keep them from moving to another state while the process is ongoing - which is about 115 days now - trying to keep my unlicensed, uninsured father-in-law from driving without resorting to something illegal - he called the police when we tried to keep the keys; they said we were stealing, etc.) without any of the rights or legal authority.

- The RSN has become just another layer of bureaucracy that passes the federal and state regulations down to the providers. There are so many requirements that the concept of local control and local decision making is significantly limited.
- The transformation would be that the Government (including the RSN) would have faith that the providers know what best for those they care for. Truly allowing the local community the opportunity to decide what is best for its own population.

-) Addiction counselors in local hospital emergency rooms that could identify and work with the aging population.

- b) Increased number of support groups for alcohol and drug addicted elderly.

- c) Caregiving facilities would be trained to provide care to individuals with

inappropriate behaviors.

- d) Treatment centers that would specialize in treating elderly and not expect the elderly to be clean and sober for a set number of days/weeks before admission.

- e) Increased funding for ECS slots.

- f) Increased funding for caregivers of residents with aggressive behavior/mental illness that create havoc and discharge from the non-ECS facility.

- g) Caregiving facilities with special training to work with aggressive behavior and mental health illness.

- What we need is an "immediate response team", who are skilled in interventions with older folks, especially with dementia, who could assess the situation at the residents home, and offer learned suggestions, and take the person to a small local geropsych unit if they were a danger to themselves or others, for a short term stay.

- *Mental Health treatment would get the same attention as any complicated medical condition…in the form of individualized care tailored to the needs of patients with attention paid to disabilities which may make accessing services more difficult.*

- A transformed mental health system would address the needs of older adults by having a geriatric team (which we used to have in the “old days” in the 1960’s) which includes an intake worker, geriatric case managers, therapists, and psychiatric nurses. There would be a primary worker assigned to the elder’s case, and this person would act as the liaison for mental health to coordinate all services with other agencies. Services would be provided in the home, as much as possible, since assessing elders in their environment will give them the most accurate picture. There would be more frequent appointments for med adjustments, and access to nursing services to triage psychiatric care in between appointments. Plans of care would be shared with other service entities with measurable goals and time frames.

QUESTION 4
What outcomes would indicate that the changes in the mental health service systems are creating results for Older Adults?

- Families and consumers would know what had happened and what is going to happen next (e.g. the process of declaring someone incompetent), and would feel empowered instead of victimized by "the system".

- Positive outcomes would be that elders can actually receive mental health services through to completion, with successful coordination of care. Positive outcomes would be that elders have one primary mental health case manager for support, as well as needed access to psychiatric nursing and psychiatrists. We should then see a decrease in chemical dependency issues, including self medicating, emotional support.

- Regular visits with doctors, a local agency that was there to serve the need.

- Fewer mentally ill adults with behavior issues would be sent to Western State or have fewer incidents of multiple hospitalizations.
- Fewer older adults would be forced to move to adult family homes or SNIF's outside of the home community.
- Behavioral incidents would be reduced in facilities because of earlier identification of:
- environmental stressors
- medical issues leading to delirium.
- identification and support of residential staff by mental health clinicians
- Quick medication evaluations and continued visits via in home prescribing by psychiatric ARNP's or Psychiatrists.

- Successful transitions to employment and living in less restrictive environment
- Reliable and accessible transportation services for all.
- Fewer people with mental illness who are homeless or reside in shelters.

- I will know the system is better when people who live here can receive treatment here.

- *Documented home visits to in home clients on COPES and MPC, phone calls to physicians and other primary providers making recommendations on medication, inservice trainings are offered on a regular basis and advertised to the aging community network. The MH network would also need reimbursement mechanisms that make this possible.*

- *Clients are served that may not have been a traditional chronically mentally ill client, but indeed has mental health related issues that need treated.*

- At the very least, the percentage of older adults receiving mental health services would increase and more closely match their percentage in the total population. In the best case scenario, appropriate mental health treatment for older adults would lead to measurable delays and decreases in inappropriate long-term care placements.

- Less involuntary hospitalization for Elders.
- Decreased number sent to nursing home.
- Outpatient services...more intense outpatient treatment for a shorter period of time. (3x/wk vs 1x/mo)

- Older adults living where they choose and getting the mental health and other related services they need to be successful staying in that place

- Fewer homeless elderly, fewer inpatient psych hospitalizations, few ER visits b older adults

- Increased ability to live in their own homes/apartments,

- Fewer skilled nursing home placements for mentally ill older adults

- Fewer older adults being hospitalized involuntarily because the system has go involved at an early stage and the intervention(s) successful.

- There would be a measurable reduction in mentally ill inmates in prisons and jails. There would be a measurable reduction in mentally ill persons living on the street.

- The assumption is that the current system is not creating results. In spite of the above mentioned issues, I think there is success to be seen in many locations. People kept in their homes, Adult Family Homes, Assisted Living Facilities, etc. People having an improved quality of life.

- *The outcome of residents in long term care facilities no longer discharged and passed around in the long term care system.*

- Fewer older adult street people.

- Increased community TX vs. institutionalization.

- Increased older adults, some with minor dementia, involved in AAA, other supp

groups and having sponsors.

- Fewer facility discharges of elderly due to behavior problems.

- Residential facility staff trained to provide appropriate care to elderly individual who are chronically mentally ill.
- *Less calls to crisis/issues addressed before they reach crisis point. Care plans address how to meet the individuals needs---ALL NEEDS---one cannot just ad one part of the person (he does not like to eat broccoli) but must address the w person (he does not like broccoli and he cannot tolerate sitting at a table when others are eating broccoli).*

State Council on Aging (SCOA) Response to MH Transformation Questions *Questions have been sent to SCOA members for potential individual responses; a formal meeting to gather input will take place at the next SCOA meeting on March 28, 2006 and will be included in the report forwarded to the next phase of the transformation effort.*	
QUESTION	RESPONSES
Within Washington State, and for all mental health services, public or private, what is working well when addressing needs of Older Adults?	
Within Washington State, and for all mental health services, public or private, what is not what is NOT working, creates barriers or fails to provide quality services and support when addressing the needs of Older Adults?	
Related to Older Adults, what would a "transformed" mental health system look like?	
What outcomes would indicate that the changes in the mental health service systems are creating results for Older Adults?	